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ABSTRACT

Few actions of the next decade will be more pertinent to the welfare of America's children than what we do about two of the most basic determinants of the quality of life of our children and their families--distribution of income among families in and by our society and size of the family and of our society. In regard to these fundamental issues, four challenges to the seventies emerge: (1) achievement of more equitable distribution of family income, (2) helping children and their families understand the full meaning of human sexuality and family planning in their lives, (3) making family planning services available to all Americans by 1974 and (4) stabilization of a population figure for our nation. Before any of the forum recommendations can become a reality, two fundamental shifts in economic direction must occur (reallocation of national expenditures from military uses and restructuring the distribution of government income from federal to state levels). Only then can federally financed and administered systems of income support, supportive human services, family planning services, and a population stabilization figure be realized. (Author/WY)

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FAMILY PLANNING AND FAMILY ECONOMICS

Report of Forum 16

1970 White House Conference on Children

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SUMMARY

Few actions of the next decade will be more pertinent to the welfare of America's children (and the world's children) than what we do about two of the most basic determinants of the quality of life of our children and their families -- distribution of income among families in and by our society and size of the family and of our society.

Under these fundamental issues, this forum feels the Conference can most effectively focus on four challenges for the seventies:

1. Family Economics - how to achieve a more equitable distribution of family income in the United States.
2. Family Life Education - how to help our children and their families understand the full meaning of human sexuality and family planning in their lives.
3. Family Planning Services - how to best achieve our national goal of making family planning services really available to all Americans by 1974.
4. Population Policy - at what point should the population of the United States be stabilized.

This forum believes that any recommendations made here or as a result of the full Conference mightily depend upon two fundamental shifts in economic direction: (1) upon the redirection of our national expenditures from military uses to much

more crucial domestic needs of our nation's children; and (2) some restructuring of the distribution of governmental income from federal to state levels.

We specifically recommend:

1. That a federally financed and administered system of income support geared to the cost of living within localities be legislated. To assure families adequate economic security this program should include supportive human services, such as comprehensive medical care.
2. That such a program, with family planning an integral part, be directed toward helping individuals cope with, and find satisfaction with, their sexual needs as responsible human beings.
3. That adequate family planning services be made available by 1974 to all who want them.
4. That population stabilization be enunciated as a national goal as soon as possible.

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CURRENT STATUS

Family Economics

A primary consideration in family living is to maintain and improve the quality of life for each family member. Planning for family life in the home and community (including health, education, and employment) requires that families have the opportunity to assess those conditions and develop practices conducive to sustaining the dignity and self-worth basic to human well-being. Family life will be greatly improved as families learn to plan for all aspects of family life and throughout changing phases in family life cycles.

Planning, as used here, is a sophisticated concept dependent on the resources of initiative and motivation within the family and society. Planning must be comprehensive, and includes assurance of income security, determination of family size, fulfillment of family needs and full utilization of family resources.

The utilization of family financial resources must be appropriate to the size of the family, because the quality of life for all family members is directly related to family size. Families can be helped to learn that by planning the number of children, each child will have a better chance to be healthy, to be educated, and to live a more satisfying life.

But limiting family size alone is no assurance that these opportunities -- social, educational, and economic -- will be available to all. Although a great majority of America's

families possess the necessary economic resources, about one-fifth of the nation's families live in poverty. In these families, hope for raising their quality of life is limited; their meager and sporadic financial resources scarcely allow meeting basic needs for survival.

No family can either plan or function adequately when financial resources are so limited that no options exist for choice or private decisions. No family should be forced to subsist on funds less than adequate as determined by budget standards; neither should a family be forced to depend on earnings from the employment of children under legal working age; nor should any adolescent child be forced to abandon school to augment family income or because costs are beyond the economic competence of the family.

We believe the issue of economics is central to planning for improved family living and therefore recommend:

> That a federally financed and administered system of income support, geared to the cost of living within localities be legislated.

Such an income support program will be an investment in human resources. The program must guarantee that each family can be confident their income will not fall below the minimum required to maintain a healthful level of living. The amount per family must, at a minimum, allow for adequate nutrition, decent housing, health care, education, clothing, and transportation. The program should provide money income rather than income in kind, and it should supplement whatever income is earned by

the family. Integrated in the plan, however, should be opportunities for greater income and employment capacity through appropriate training programs and relevant jobs.

In combination with the income plan an acceptable minimum wage related to the costs of living should be established throughout the nation. Government programs should not function to subsidize some industries by maintaining low wage scales.

The complexities of our current society also demand supportive services to assure families of adequate economic standards. The income program should make available to all families:

- Comprehensive health care, including preventive and therapeutic care. Programs must tailor the distribution and organization of health care services to meet the needs and life styles of the populations served.
- Educational endeavors, as a continuing process, beginning with the preschool child and extending through adulthood. An income support program must include funds for: (1) those school expenses not provided by the public school system; and (2) vocational, technical, and/or professional training for family members able to and wishing to improve their marketable skills.
- Social services to assist families in crises which

may be a result and/or a combination of economic stress. Most effective use of social services will not be through crisis intervention alone but through preventive outreach services to help families cope with social problems before they become critical.

- Day care services. For parents to participate in educational training programs and for parents to be free to secure employment and increase family income, proper care of children must be ensured. Services should include care for infants, preschoolers, and school-age children, and must also seriously consider providing care for the child with minor ailments, who, by regulations, is not allowed to remain in a group care setting.

Children must be given every opportunity to grow to adulthood in an environment of love and caring. Security is the right of every child, and must be guaranteed. Where the efforts of the individual family cannot adequately provide this security, it becomes the responsibility of the larger society. For many children without parents, adoption offers the best security. If this segment of our child population is to have an equal chance to live normal lives, national leadership must modernize and humanize recruitment and placement policies of all public and private adoption agencies to bring together potential adoptive adults and children without parents.

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Family Life Education

Until the 1960's the family planning and sex education movements developed as essentially separate entities. For decades, family planning meant contraception, while sex education meant teaching human sexuality, with the subject of contraception avoided as possibly inciting increased sexual encounters among students. With the last decade, however, several important developments have led to the realization that family planning and sex education are interdependent. For the first time, representatives of the major national organizations concerned with family planning and sex education have met, determined the areas of mutual concern, and decided upon a path of collaboration.

Some of the many reasons for this fusion are:

1. Development of sex education models which include an understanding of family planning within a context of responsible behavior.
2. The realization that availability of contraception alone does not ensure utilization especially where pregnancy planning is most crucial. Family planning has been realized in its broadest sense only when linked to an understanding of particular peoples' life priorities and mediated through an appropriate education system.
3. The sexual climate in which concepts related to actual behavior can be expressed openly and reflected in education, services, and laws.

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We wish to focus the attention of the White House Conference upon the current understanding of sex education, who is doing it and for whom, the current state of training in this area, and the needs for further program development and evaluation.

Sexuality and Sex Education. The concept of sexuality generally accepted today is that expressed by Kirkendall and Rubin in their SIECUS* Guide Sexuality and the Life Cycle: "...sexuality as a recognition that sex expression is a deep and pervasive aspect of one's total personality, the sum total of one's feelings and behavior not only as a sexual being, but as a male or a female."

Sex education deals with sexual identity as an important part of an individual's self-image. It is directed towards helping individuals cope and find satisfaction with their sexual needs as responsible human beings.

Sex Education and Family Planning. Family planning is one of the subjects most often asked about by students in the reproductive age group. Family planning education and counseling has a potent impact upon men and women in their day-to-day expression of sexuality. For example, although many young people of high school and college age are not prevented by social or moral strictures from having sexual intercourse, they rarely use birth control. However, where family planning and sexual

*The Sex Information Education Council of the United States.

responsibility have been built into a sex education program, avoiding sexual exposure without contraception soon becomes the norm.

Who is Doing Sex Education.

1. The schools. The National Association of Independent schools has been involved in sex education programs for over 30 years, and within the last decade many public school systems have also started programs.
2. The colleges. The old feeling that college would be too late to learn about sexuality has now become outdated. Programs have developed within the last decade to help students understand themselves as sexual beings and cope with the issues encountered during their college years. Several of these have been described most recently at the American Public Health Association's Annual Meeting in Houston and at a special SIECUS Meeting on College Sexuality. Even at an early stage of development, the programs appear much in demand on college campuses.
3. The professional schools and graduate schools. The medical schools have taken the lead among the graduate schools in developing sex education as an integral part of the curriculum. About two-thirds of this

country's medical schools now offer programs in human sexuality. Programs have also been developed in many of our teachers' colleges and program beginnings are appearing in schools of social work, law, divinity, and nursing.

4. The churches. Sex education programs developed and sponsored by the church community have been important factors in reaching both school age and older segments of the population. Many national church groups formally advocate responsible sex education as an essential building block of a stable family life.
5. Professional organizations. Training programs, conferences, and publications relating to family planning and sex education have been sponsored by many national organizations. Support has come from private foundations as well as the federal government.

Organizations Working in Standards and Training. Many organizations have expressed a vital interest in sex education, family planning, and the relationship between the two. SIECUS, Planned Parenthood-World Population and AASEC (American Association of Sex Educators and Counselors) focus on these concerns. Some of the many other groups have also made significant contributions to the field:

National Council of Family Relations

American Social Health Association

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National Council of Churches

American Medical Association

American Public Health Association

American College of Obstetricians and Gynecologists

American Home Economics Association

National Medical Association

American Academy of Pediatricians

National Conference of Catholic Churches.

PROGRAM NEEDS

Family planning in collaboration with sex education should be evaluated in longitudinal studies. Changes in knowledge, attitude, and behavior which result from such education have only recently started to be studied. The impact of such a program upon the overall health status of a population should be measured. Training programs that have been developed need to be evaluated both for their effectiveness and general applicability.

Service programs incorporating both sex education and family planning have already started to make an impact upon the problems of population. The comprehensive, teen-age unwed mother programs are an example. These services need to be expanded and the principles learned from them applied to new programs aimed at the other critical issues we face.

The recognition of family planning as an integral part of

family life indicates the need for making sex education part of family planning at all levels of education and counseling. To realize the potential of such education it is important to:

1. Survey existing programs of research, training, and services to select programs for evaluation and expansion.
2. Support the establishment of a clearing house for existing organizations to enable better dissemination of information about sex education and family planning.
3. Make funds available to permit incorporation of sex education programs in all family planning projects and to provide for training of personnel in this field.

Family Planning Services

President Nixon in his July 1969 message to Congress on population growth reaffirmed as national policy the right of all American families to plan the number and timing of children that they want. He also established as a national goal the provision of adequate family planning services by 1974 to all who want but cannot afford them.

The first White House Conference on Children and Youth to recommend family planning was in 1960 (by a divided vote, rec. no. 106). That occurred shortly after the American Public Health Association had adopted its historic policy statement on population in 1959 and after President Eisenhower had rejected birth control as a proper governmental activity or responsibility.

Thus, it has taken most of the decade for the nation to complete its remarkable reversal of policy in this crucial area. Meanwhile, the states and cities, with slowly increasing federal financial support, have made a good beginning on implementing the policy by making family planning services a part of public health services.

Much confusion exists regarding the goals of public family planning programs. Some of the poor, particularly poor Blacks and poor Chicanos, suspect the motives of politicians and bureaucrats in reversing ages old policy in any matter affecting the welfare of the poor. When the policy affects so vital an issue as how many children they have and some legislators and bureaucrats state their primary interest as saving tax dollars that would otherwise be spent for welfare support, people's suspicions increase. When even a few legislators or bureaucrats try to make family planning a condition for receiving welfare payments, the poor certainly have cause to be alarmed. Religious conflicts about birth control are also evident. Although the last of the puritanically induced Comstock laws was repealed during the 1960's, puritanical feelings about sex and birth control linger and the Catholic Church in the United States in 1970 remains sharply divided on family planning.

The basic objective of public family planning programs in the United States today is to enable the poor, who rely upon public services for family planning, to have planning opportunities

at least as good as those of other Americans. Each family has the right to decide for itself on the basis of social norms and its own family goals and resources when and how many children to have. Safeguards are essential to protect welfare recipients and members of religious and racial minority groups from any type of coercion. A wide range of services should be provided so that each couple can select a contraceptive method best suited to their beliefs and living conditions.

National fertility surveys of the United States in 1955, 1960, and 1965 have documented the fact that, despite legal and religious restrictions, the American people use contraception extensively. Excluding the one-tenth of the population of reproductive age who are definitely sterile (largely because of surgical sterilizations, half of which were performed primarily for treatment of a pathological condition), about eighty-five percent have used some method of contraception. Most Americans obtain their family planning services and supplies from private physicians, pharmacists, and other consumer outlets for the various kinds of contraceptives produced by private industry with quality controlled by the Federal Food and Drug Administration.

Use of different methods of contraception has shifted rapidly as new, more effective methods have become available. In 1955, 27 percent of contraceptors used condoms, 25 percent diaphragms, about 22 percent rhythm. By 1965, 24 percent used oral pills, 18 percent condoms, 13 percent rhythm, and 10 percent

diaphragms, and a small but increasing proportion intrauterine devices.

Until the early 1960's, however, with very few exceptions family planning services were not permitted as part of health and medical services provided by government for those who could not afford private care. This policy was, in effect, forcing many poor women to bear unwanted children and was partly responsible for the higher natality rates of the poor. The realization of this by health workers in the late 1950's and early 1960's resulted in public health leadership to make family planning equally available to all. Although the tax savings from elimination of obstetric costs and welfare payments certainly made new family planning programs more palatable to legislators, rarely were they the prime motivation. Similarly, while some legislators and bureaucrats in some sections of the country (and some supporters of private family planning organizations) support these programs because they want to see Black natality rates come down, it is equally clear that the large majority of health workers responsible for public family planning programs wish to prevent coercion of any kind. Church groups, welfare organizations, Black groups, and the courts also remain alert to prevent misuse. Furthermore, except for surgical sterilization, present methods are fully under individual control.

The poor have responded remarkably to the availability of services. Rarely has a new health measure, especially a

controversial one, been so readily and widely accepted. In public obstetric services where only one-quarter to one-third of women usually returned for postpartum checkups, over three-quarters commonly return once family planning has been included. This validates earlier surveys that indicated that the poor wanted family planning. Nevertheless, public programs are still too few and too young to know their effects on narrowing natality rates between the poor and other Americans.

We are still a long way from achieving the national goal of providing adequate family planning services by 1974 to all who want them. The number of couples in the United States who want but cannot afford family planning services is estimated at five million, essentially the same couples who presently must depend on tax-supported medical care for delivery of their babies. In the United States where 97 percent of babies are delivered in hospitals, it would appear a simple matter to add family planning to existing health services for childbearing families. However, in much of our country prenatal, postnatal, and infant health services for the poor are still (despite much progress during the 1960's) inadequate, fragmented, uncoordinated, and, for many, difficult to obtain. Family planning services for the poor are thus inextricably related to the problems of developing and financing comprehensive personal health services for poor families.

Family planning services for the poor, however, should not

and need not wait until comprehensive personal health services are available. Family planning services can be provided in the interim by various combinations of services and facilities, depending largely on pre-existing services and local interests. Examples are:

1. As an essential element of comprehensive family care by private physicians, group practices, hospitals, pharmacists, and other resources in states implementing Title XIX of the Social Security Act
2. As an essential element of comprehensive maternity care in all federally financed maternity and infant care services
3. As an essential element of public hospital and health department inpatient, outpatient, and home maternal health services
4. As an essential element of family services provided by community and neighborhood centers financed by the Office of Economic Opportunity
5. As a separate, important activity in private or public family planning clinics where none of the above resources are locally available.

Whatever form such interim services may take, it should be recognized that anything short of family planning services as part of comprehensive family health services is a temporary

expediency. In no way should it be used to delay development of comprehensive care.

Although public family planning services in the United States have grown impressively in recent years, it is estimated that the combined efforts of these new public services together with the expanded efforts of the private Planned Parenthood Federation in 1970 still reach under 35 percent of families who want but cannot afford them. What is needed to reach 100 percent by 1974?

Money. Given the present state of financial resources of our states and cities, the predominant role of the federal income tax, and the probability that any significant redistribution of federal funds to states and cities will take at least several years, it is clear that funds must come from the federal government. Seemingly agreed on this, the Administration and the Congress by December 1970 hopefully will have passed legislation authorizing necessary funds.

Local Planning. Maximum local participation by the poor in determining any family planning program intended to help them is a necessity. Family planning is controversial and the motivations varied in different areas of the United States. Some examples of effective local programs will be presented at the Conference.

Manpower. Even with money and good local planning, essential manpower must be provided in some areas. Family planning programs

offer good opportunities for pioneering use of specially trained medical assistants and neighborhood workers, not only to achieve the 1974 goal in family planning services but also to provide the base for additional future services.

Teen-agers. No area at present raises more controversy or more heartbreak than the problems of teen-age pregnancies; nowhere are changes in laws and customs and ways of providing services more urgently needed. Examples of success in this area will also be presented in December.

Program Information. Assembling basic information on public family planning programs (even such simple data as what proportion of families in a given area are currently contraceptive users in public programs) has been frustrated by the great variety of financing sources. Promising efforts to solve this problem are now under way in the federal government and in several states.

Population Policy

Family planning and family economics must also be considered in the broad context of the crises of population growth facing all mankind. The size, growth, and distribution of the United States population, subjects formerly the esoteric preserve of the scholarly profession of demography, have in recent years become increasingly debated issues of public policy. Not only is there general awareness of the calamitous consequences of rapid population growth in less developed areas of the world, but there

is also widespread concern that our own population has been growing, and will continue to grow, at a rate that threatens to produce acute social, educational, economic, and environmental problems.

Wide disagreement exists in the debate on the growth of the United States population. It begins with the question of whether there is or will soon be a population problem. Even where there is agreement that a population problem exists, there is no unanimity on the definition of the problem or proposals for its solution.

On one side many view population growth as a problem second only to war. A number of population experts have handed mankind a stark choice -- population control or race to oblivion. They depict overpopulation as the dominant problem in all our personal, national, and international planning. Advertisements speak of the horrors of the "population bomb" and the "population explosion" and even the National Academy of Sciences has warned that "in the very long run, continued growth of the United States population would first become intolerable and then physically impossible."

On the other side, experts contend that the country is not in a population crisis and does not face an impending crisis in the sense of having more people than the nation can sustain at a high level of economic and cultural well-being. They point out that the trend of the annual growth rate has been downward since

the pre-Civil War period. Our population is now growing at only about one percent per year and while this rate may rise during the 1970's, as the proportion of women of childbearing age increases, it should then recede to its present level or perhaps even below it.

Support for this point of view appears in the recent decision of the United States Census Bureau to lower its estimate of the range of population growth of the United States population by the year 2000. Only last year, the Census Bureau projections ranged from 80 to 160 million additional people by the year 2000, with a median projection around 100 million -- a 50 percent increase in our population during the next three decades. Now it is considered just as possible that fertility might drop in a decade or so to a level of population stabilization (assuming measures were also taken to reduce immigration, if necessary).

In the midst of this debate, a central question goes unanswered: the ideal size of America's population. Any claim that a country's population is too large or too small implies an ideal size, and some standard by which to measure deviation. But to date, no population analyst or policymaker has developed any objective, overall criteria for arriving at an "optimum population" for a given area at a given time.

Any search for an optimum population size is complicated by social, technological, and cultural change. At the time of Columbus, what is now the United States supported hardly

more than a million people; because of the harsh conditions of life in many areas, that level might have seemed overpopulated then. Yet, four and a half centuries later, the same land supports 200 times as many -- at a material level of living vastly higher than that of its original inhabitants.

Whatever might be said of the present or impending population problem in the United States, it cannot be called Malthusian in nature. Our population is not pressing upon the domestic food supply, is not threatened with the "positive checks" of famine or pestilence, and is entirely independent of internal population pressures that lead to the third so-called positive check -- war. The population "problem" turns on a very different set of factors than those envisioned by Thomas Malthus; it is related instead to the quality and safety of our physical and social surroundings.

In the nonindustrialized countries, population increase can prevent the fulfillment of basic human needs -- the need for enough to eat, for a place to live, for a job. In the industrialized countries, the increase may deprive us of the personal freedoms, pleasures, and quality of environment that become possible once basic human needs are met. The quality of life, then, is the criterion for judging the population problem in the United States -- the kind of life one can lead in terms of health, education, housing, work, play, and personal freedom.

At President Nixon's request Congress established in March

1970 the Commission on Population Growth and the American future to study alternatives for United States population growth and their consequences for our quality of life. The White House National Goals report of July 4, 1970 also recognizes the focal nature of population growth (and distribution) goals relative to all other national goals.

The White House Conference on Children provides an excellent opportunity for citizen participation in these national policy discussions on population growth as it affects America's children. As a basis for these discussions, we recommend a forthright enunciation of population stabilization as a national goal as soon as possible.

We urge such a statement because:

1. United States population growth must stabilize eventually. Only a small fraction of finite earth is ours to inhabit, and the problems facing the country grow more severe as our population grows.
2. A stationary population, or zero population growth, means that the birth rate equals the death rate and that net migration is zero. With a stationary population, each female, on the average, replaces herself during her lifetime with one female child who lives and in turn replaces herself. Given the present death rates for females in the United States and the present ratio of males to females at birth, this means that the average woman could have 2.11 live births for replacement

reproduction. Given the present proportions, married and sterile, the average married woman should have 2.47 live births (if all births occurred in wedlock).

The achievement of replacement reproduction in the United States without coercion appears possible. The latest national data indicates that if perfect contraception and/or induced abortion were available, so that families had only those children they wanted, in 1965 we would have had an average 2.5 live births per woman. Changes in education, in alternative roles for women, and in present economic incentives might well close the gap to the 2.11 needed for stabilization. Particular attention should be paid to encouraging women to find satisfactions beyond motherhood. And the process would be speeded by governmental programs and incentives to employers to provide part-time work opportunities and high quality child care, plus assurance of equal pay and equal jobs.

3. A stable population will require some decrease in average family size for all Americans. But the groups most essential to changing birth and family size patterns are affluent and middle-class Americans: during 1960-65, they produced 70 percent of our births (and population growth).
4. Even if replacement reproduction were achieved by 1971,

about 70 years would be required to reach a stable population (zero population growth). Since birth rates are influenced by the proportion of the population in the reproductive age group, 15-44, the high natality levels following World War II have led to a larger proportion of women in that age group than there would be in a stationary population. Thus the population of the United States would continue to grow for about 70 years before plateauing at 285 million. The longer we wait to achieve replacement reproduction, the larger that population will be.

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